Current Sport _____ SHORELINE SCHOOL DISTRICT Sport Physical is good from 24 months based on the **date of the actual physical exam** by the Health care practitioner. 1/14

SECONDARY STUDENT HEALTH REPORT

All sections outlined in bold boxes are to be completed by health care provider

HEALTH HISTORY Completed by Parent/Guardian

NAME_____BIRTHDATE_____GRADE_____

ADDRESS_____PHONE_____

PARENT/GUARDIAN_____PHYSICIAN_____

	YES	NO	
1.	_____	____	Any chronic or recurrent illnesses?
2.	_____	____	Any illness lasting more than a week?
3.	_____	____	Any hospitalizations?
4.	_____	____	Any surgery other than tonsillectomy?
5.	_____	____	Any injuries requiring treatment by a physician?
6.	_____	____	Presently taking any medications?
7.	_____	____	Any problems with blood pressure or heart?
8.	_____	____	Any dizziness, fainting, convulsions or frequent headaches?
9.	_____	____	Have you ever "passed out" or been "knocked out"?
10.	_____	____	Wear eyeglasses or contact lenses?
11.	_____	____	Wear any dental appliance such as braces, bridge or plate?
12.	_____	____	Allergic to ANY medication (aspirin, penicillin, etc.)?
13.	_____	____	Any knee or ankle injury and/or surgery?
14.	_____	____	Been diagnosed with a concussion? Date? (mth/yr) _____
15.	_____	____	Any history of neck injury?
16.	_____	____	Any other joint sprains or dislocations (shoulder, wrist, finger, etc.)?
17.	_____	____	Any broken bones (fractures)?
18.	_____	____	Any organ missing other than tonsils (appendix, eye, kidney, testicles)?
19.	_____	____	Any heat exhaustion or heat stroke?
20.	_____	____	Any reasons why this applicant should not participate in sports?
21.	_____	____	Any menstrual problems?
22.	_____	____	Do you have to stop while running twice around a 1/4 mile track?
23.	_____	____	Have any family history of "heart problems" under age 50?

PARENTAL PERMISSION I give my permission for the above-named child to participate in the sport(s) approved by the examiner under the auspices of the Shoreline School District and authorize the coach or other responsible official to obtain emergency medical care for my child should such become necessary during participation and I am not immediately available.

DATE_____ PARENT/GUARDIAN_____

EXAMINER'S COMMENTS ON HISTORY ("yes" answers above):

Exam Date_____ **PHYSICAL EXAMINATION**

HEIGHT_____inches **WEIGHT**_____Pounds **M**___ **F**__ **AGE** _____Years

PULSE____ **BLOOD PRESSURE**_____**VISUAL ACUITY**: Left 20/
Right 20/

HEARING Left___ Right__

NORMAL	ABNORMAL*	NORMAL	ABNOMAL*
( ) 1. Head	( )	( ) 9. Neurological	( )
( ) 2. Eyes (Pupils), ENT	( )	( ) 10. Skin	( )
( ) 3. Teeth	( )	( ) 11. Physical Maturity	( )
( ) 4. Chest	( )	( ) 12. Spine, back	( )
( ) 5. Lungs	( )	( ) 13. Upper Extremities	( )
( ) 6. Heart	( )	( ) 14. Lower Extremities	( )
( ) 7. Abdomen	( )	( ) 15. Urinalysis	( )
( ) 8. Genitalia	( )		

* Describe findings _____

List any immunizations given at this visit_____

Recommendation:
I certify that I have examined this pupil on the date above and find him/her physically able to compete in supervised interscholastic activities as described below.
( ) No contraindications to FULL participation
( ) Has following limitations but may participate:

( ) Participation contraindicated for following reasons:

Student may participate in ACTIVITIES NOT CROSSED OUT BELOW for the next 24 months, which could include middle school & high school competition.

BASEBALL BASKETBALL CROSS COUNTRY DRILL FOOTBALL GOLF WRESTLING GYMNASTICS SOCCER SOFTBALL SWIMMING TENNIS TRACK CHEER VOLLYBALL OTHER_____

Date of Signing:_____ EXAMINER'S SIGNATURE_____

Examiner's Stamp EXAMINER'S NAME_____

TITLE_____

PHONE_____